45 day 9-2-17 / 70th 9-22-17

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1 7a.1	445030	A. BUILDING _____ B. WING _____	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC MAURY REGIONAL TRANSITIONAL CARE CENTER	5010 TROTWOOD AVE COLUMBIA, TN 38401

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #39664, #39995, #40087, and #40134 were completed on 7/17/17 - 7/19/17 at NHC- Maury Regional Transitional Care Center. Deficiencies were cited related to complaint investigation #40087 and #40187 and were cited and the recertification survey under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157	MD was notified on patient #168 DON reviewed all patients on Fentanyl patches for placement to ensure no evidence of misappropriation r/t missing patches. Or failure to notify MD Regional Nurse will in-service all nurses regarding abuse and notification of MD /& DON regarding clinical complications DON/Team Coordinator or pharmacy consultant will QA 2 patients on fentanyl patches for any evidence of misappropriation and to ensure MD/DON is notified when appropriate Weekly x 4 weeks, then monthly x3, then quarterly or until substantial compliance is met	7/18/17 7/18/17 8/8/17 ongoing

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Administrator 8-7-17

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 /s f llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued g( )erticipation.

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to notify the Physician of a clinical complication for one resident (#168) of 3 residents reviewed for abuse. The findings included: Medical record review revealed Resident #168 was admitted to the facility on 7/19/16 with diagnoses including Vascular Dementia with Behavioral Disturbance, Aphasia following Cerebral Infarction, Attention and Concentration Deficit, Dysphagia, Anxiety, Depression, Hypertension, Difficulty in Walking, Chronic Pain,	F 157		

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F 157	Continued From page 2 and Contracture of Right Knee. Medical record review of the Quarterly Minimum Data Set dated 4/18/17 revealed a Brief Interview for Mental Status could not be conducted because the resident was rarely/never understood. Medical record review of a nurse note by Registered Nurse (RN) #1 dated 7/18/17 at 8:50 AM revealed "did not find fentanyl patch [narcotic pain medication transdermal patch] to R [right] chest as documented. will ask on coming nurse to double-check and if none found, to place another patch." Interview with RN #1on 7/19/17 at 2:25 PM via telephone revealed she worked the 7PM to 7AM shift the night of 7/17/17 and cared for Resident #168. Further interview revealed she noticed the Fentanyl patch was missing around 4 AM. Continued interview revealed RN #1 reported the missing Fentanyl patch to Licensed Practical Nurse (LPN) #1 at shift change and asked her to get it replaced if it wasn't found. Interview with LPN #1 on 7/19/17 at 2:55 PM via telephone revealed she worked 7/18/17 from 7 AM to 7 PM and cared for Resident #168. Further interview revealed RN #1 told her at shift change the Fentanyl patch was missing. Continued interview confirmed LPN #1 intended to notify the Physician of the missing Fentanyl patch but failed to do so.	F 157		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 3 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 226	F225 Patient #379 was discharged investigation complete on patient #168 — 11/23/16 7/22/17 All patients reviewed for incidents of unknown origin to ensure an investigation was complete as indicated. — 7/18/17 All patients with MD order for Fentanyl patches were reviewed to ensure no evidence of misappropriation — 7/18/17 Regional Nurse will inservice all nurses regarding reporting of incidents and procedures regarding missing fentanyl patches — 8/8/17 DON/ADON Team Coordinator will review incidents of unknown origin to ensure appropriate investigation is complete weekly x 4 weeks, then monthly x 3, then quarterly or until subsaintal compliance is met — Ongoing DON/Team Coordinator or pharmacy consultant will QA 2 patients on fentanyl patches for any evidence of misappropriation and to ensure	

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F 225	Continued From page 4 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to investigate injuries of unknown origin for 1 resident (#379) and failed to initiate an investigation in a timely manner for a missing pain patch for 1 resident (#168) of 35 residents reviewed in Stage II. The findings included: Review of facility policy, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property, and Exploitation, revised 11/28/16 revealed "...abuse is the willful infliction of injury, unreasonable	F 225	MD/DON is notified when appropriate Weekly x 4 weeks, then monthly x3, then quarterly or until substaintal compliance is met	ongoing

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F 225	Continued From page 5 confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...An injury should be classified as an "injury of unknown source" when both of the following conditions are met: (a) The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and (b) The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time...All events reported as possible abuse, neglect, or misappropriation of patient property will be investigated to determine whether the alleged abuse, neglect, misappropriation of patient property, or exploitation did or did not take place...The Administrator or Director of Nurses will determine the direction of the investigation once notified of alleged incident..." Review of facility policy, Miscellaneous Special Situations, Discrepancies, Loss and or Diversion of Medications, dated 6/2016 revealed "...All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed...Immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON), Consultant Pharmacist and Director of Pharmacy are notified and an investigation conducted. The Director of Nursing leads the investigation...Appropriate agencies, required by state regulation will be notified..." Medical record review revealed Resident #379 was admitted to the facility on 9/23/16 and discharged 11/23/16 with diagnoses including Congestive Heart Failure, Hypertension,	F 225		

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F 225	Continued From page 6 Dementia, and Obstructive Sleep Apnea. Medical record review of the 14 day Minimum Data Set (MDS) dated 10/10/16 revealed Resident #379 scored 15/15 on the Brief Interview for Mental Status, indicating she was alert and oriented. Continued review of the MDS revealed Resident #379 required extensive assistance of 2 people for transfers and toileting; extensive assistance of 1 person for dressing and bathing; assistance of 1 person for grooming; supervision for eating; and was frequently incontinent of bowel and bladder. Medical record review of nursing notes dated 10/28/16 revealed Resident #379 had bilateral upper extremity skin tears. Continued review of nursing notes dated 11/4/16 revealed the resident had multiple skin tears to bilateral upper extremities. Review of incident reports revealed none were completed for these injuries and no investigations were completed for multiple injuries of unknown origin.. Interview with the Director of Nursing (DON) on 7/19/17 at 4:30 PM in the conference room, confirmed there were no incident reports for the skin tears which occurred on 10/28/17 and 11/4/17. Continued interview with the DON confirmed there was no investigation into either injury of unknown origin. Medical record review revealed Resident #188 was admitted to the facility on 7/19/16 with diagnoses including Vascular Dementia with Behavioral Disturbance, Aphasia following Cerebral Infarction, Attention and Concentration	F 225		

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F 225	Continued From page 7 Deficit, Dysphagia, Anxiety, Depression, Hypertension, Difficulty in Walking, Chronic Pain, and Contracture of Right Knee. Medical record review of the Quarterly MDS dated 4/18/17 revealed a Brief Interview for Mental Status could not be conducted because the resident is rarely/never understood. Medical record review of a nurse note dated 7/18/17 at 8:50 AM by Registered Nurse (RN) #1 revealed "did not find fentanyl patch [narcotic pain medication transdermal patch] to R [right] chest as documented. will ask on coming nurse to double-check and if none found, to place another patch." Interview with RN #1 on 7/19/17 at 2:25 PM via telephone revealed she worked the 7PM to 7AM shift the night of 7/17/17 and cared for Resident #168. Further interview revealed she checked the placement of the Fentanyl patch around 4 AM and could not find it. Continued interview revealed RN #1 reported the missing Fentanyl patch to Licensed Practical Nurse (LPN) #1 at shift change and asked her to get it replaced if it wasn't found. Interview with RN #3, Unit Manager on 7/19/17 at 2:45 PM in the conference room, when asked her expectation of when staff should notify her of a missing Fentanyl patch on a resident revealed she would expect to be notified immediately. Continued interview revealed she was notified of the missing Fentanyl patch for Resident #168 at approximately 9 AM on this date by LPN #2. Interview with the DON on 7/19/17 at 4:38 PM in the conference room revealed she did not find out	F 225		

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F 225	Continued From page 8 about the missing Fentanyl patch until this morning, and an investigation had since been initiated. Continued interview revealed RN #1 did not report the missing Fentanyl patch to the unit supervisor or the DON. Further interview revealed the incident had not been reported to the state agency. Continued interview with the DON confirmed RN #1 did not report the possible misappropriation of narcotic medication in a timely manner and the facility did not report to the State Agency in the required time period.	F 225		
			F514	
F 514 SS=D	483.70(l)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (l) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 514	Record corrected on Patient #168 DON reviewed MAR for all patients on pain patches to ensure accurate documentation Regional nurse to in-service nurses on accurate documentation regarding missing pain patch DON/Team Coordinator or pharmacy consultant will QA 2 patients on fentanyl patches for any evidence of misappropriation and to ensure MD/DON is notified when appropriate Weekly x 4 weeks, then monthly x3, then quarterly or until substantial compliance is met	8/1/17 8/1/17 8/8/17 ongoing

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F 514	Continued From page 9 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately document on the Medication Administration Record (MAR) for one resident (#168) of 35 residents reviewed in stage 2 for accurate documentation. The findings included: Medical record review revealed Resident #168 was admitted to the facility on 7/19/16 with diagnoses including Vascular Dementia with Behavioral Disturbance, Aphasia following Cerebral Infarction, Attention and Concentration Deficit, Dysphagia, Anxiety, Depression, Hypertension, Difficulty In Walking, Chronic Pain, and Contracture of Right Knee. Medical review of the Quarterly Minimum Data Set dated 4/18/17 revealed a Brief Interview for Mental Status could not be conducted because the resident is rarely/never understood. Medical record review of the MAR for July 2017 revealed "...CHECK - Patch placement every shift..." (narcotic pain medication transdermal patch). Continued review revealed documentation the patch was "not found" on the night shift on 7/17/17. Further review revealed documentation	F 514		

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F 514	Continued From page 10 for patch placement on 7/18/17 as "RT AC" (right subclavian). Interview with Licensed Practical Nurse (LPN) #1 on 7/19/17 at 2:55 PM via telephone when asked did the resident have a Fentanyl patch (narcotic pain medication transdermal patch) in place on 7/18/17 stated "she could not find it." Continued interview when asked about the documentation of checking the patch placement for the Fentanyl patch on 7/18/17 stated "I think I put it was on but I should have put not in place." Further interview revealed LPN #1 stated "didn't document it right." Interview with the Director of Nursing on 7/19/17 at 4:38 PM in the conference room when asked about LPN #1's documentation regarding the Fentanyl patch placement on the 7/18/17 day shift revealed it was incorrect. Continued interview with the DON confirmed the facility failed to accurately document the Fentanyl patch placement on 7/18/17 day shift for Resident #168.	F 514		